DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Transgender Services, Section 8.735
Rule Number: MSB 19-09-04-B
Division / Contact / Phone: Health Programs Office / Whitney McOwen / 303-866-4441 / Jessica Pekala / 303-866-2107

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 19-09-04-B, Revision to the Medical Assistance Act Rule concerning Transgender Services, Section 8.735

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.735, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date: N/A
   Is rule to be made permanent? (If yes, please attach notice of hearing). <Select One>

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.735.4.F with the proposed text beginning at 8.735.4.F.1.d.i through the end of 8.735.4.F.1.d.i. This rule is effective March 2, 2020.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Transgender Services, Section 8.735
Rule Number: MSB 19-09-04-B
Division / Contact / Phone: Health Programs Office / Whitney McOwen / 303-866-4441 / Jessica Pekala / 303-866-2107

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The proposed revision to this rule will remove the requirement that members seeking a mastectomy first undergo twelve continuous months of hormone therapy. The Department is pursuing this revision in response to stakeholder feedback that the hormone therapy requirement is an unnecessary barrier to mastectomy surgeries.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   45 CFR Part 92

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2019);

Initial Review	**12/13/19**	Final Adoption	**1/10/20**
Proposed Effective Date	**3/2/20**	Emergency Adoption	**[date]**
			DOCUMENT #

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Transgender Services, Section 8.735
Rule Number: MSB 19-09-04-B
Division / Contact / Phone: Health Programs Office / Whitney McOwen / 303-866-4441 / Jessica Pekala / 303-866-2107

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Members with a diagnosis of gender dysphoria seeking mastectomy surgeries under the Transgender Services benefit will benefit from this proposed rule revision, which removes the unnecessary barrier of receiving twelve continuous months of hormone therapy prior to being eligible for the surgery.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   Treatment of gender dysphoria is unique for every member and some members do not wish to receive hormone therapy as a part of their transition. Members seeking mastectomy surgeries who are otherwise eligible for the surgery will be able to receive it without needing to complete a year of hormone therapy.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   The Department does not expect an increase in utilization as a result of the proposed rule revision, and thus no fiscal impact is anticipated.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   The probable cost of inaction is a continued unnecessary burden for members seeking mastectomy surgery under the Transgender Services benefit. The benefit of the proposed revision is the removal of that burden for members.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   There are no less costly or less intrusive methods for achieving the purpose of the proposed amendment to the Transgender Services rule.

DO NOT PUBLISH THIS PAGE

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   There are no alternative methods for achieving the purpose of the proposed rule.

8.735 TRANSGENDER SERVICES

8.735.1 Definitions

Cross Sex-Hormone Therapy means a course of hormone replacement therapy intended to induce or change secondary sex characteristics.

Gender Confirmation Surgery means a surgery to change primary or secondary sex characteristics to affirm a person's gender identity. Also known as gender affirmation surgery or sex reassignment surgery.

Gender Dysphoria means either: gender dysphoria, as defined in the Diagnostic Statistical Manual of Mental Disorders, 5th Edition (DSM-5), codes 302.85 or 302.6; or gender identity disorder, as defined in the International Classification of Disease, 10th Edition (ICD-10), codes F64. 1-9, or Z87.890.

Gonadotropin-Releasing Hormone Therapy means a course of reversible pubertal or gonadal suppression therapy used to block the development of secondary sex characteristics in adolescents.

8.735.2 Client Eligibility

8.735.2.A. Clients with a clinical diagnosis of gender dysphoria are eligible for the transgender services benefit, subject to the service-specific criteria and restrictions detailed in Section 8.735.4.

8.735.3 Provider Eligibility

8.735.3.A. Enrolled providers are eligible to provide transgender services if:

1. Licensed by the Colorado Department of Regulatory Agencies or the licensing agency of the state in which the provider practices;

2. Services are within the scope of the provider's practice; and

3. Knowledgeable about gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria.

8.735.4 Covered Services

8.735.4.A. The following requirements apply to all covered transgender services:

1. Client has a clinical diagnosis of gender dysphoria;

2. Requested service is medically necessary, as defined in Section 8.076.1.8.;

3. Any contraindicated medical and behavioral health conditions have been addressed and are well-controlled;

4. Client has given informed consent for the service; and

5. Subject to the exceptions in §13-22-103, C.R.S., if client is under 18 years of age, client's parent(s) or legal guardian has given informed consent for the service.

8.735.4.B. Requests for services for clients under 21 years of age are evaluated in accordance with the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program criteria detailed in Section 8.280.

8.735.4.C. Behavioral health services are covered in accordance with Section 8.212.

8.735.4.D. Hormone Therapy

1. Covered hormone therapy services are limited to the following:

a. Gonadotropin-Releasing Hormone (GnRH) Therapy

i) GnRH therapy is a covered service for a client who:

1) Meets the criteria at Section 8.735.4.A.;

2) Meets the applicable pharmacy criteria at Section 8.800; and

3) Has been referred to a licensed behavioral health provider and has a plan in place to receive behavioral health counseling concurrent with GnRH therapy.

b. Cross-Sex Hormone Therapy

i) Cross-sex hormone therapy is a covered service for a client who:

1) Meets the criteria at Section 8.735.4.A.; and

2) Meets the applicable pharmacy criteria at Section 8.800.

ii) Other cross-sex hormone therapy requirements

1) Prior to beginning cross-sex hormone therapy, a licensed behavioral health provider, with whom the client has an established and ongoing relationship, must determine that any behavioral health conditions or concerns have been addressed and are well-controlled.

2) For the first twelve (12) months of cross-sex hormone therapy:

a) Client must receive ongoing behavioral health counseling at a frequency determined to be clinically appropriate by the behavioral health provider; and

b) Client must receive medical assessments at a frequency determined to be clinically appropriate by the prescribing provider.

8.735.4.E. Permanent Hair Removal

1. Permanent hair removal is a covered service when:

a. Client meets the criteria at Section 8.735.4.A.; and

b. Used to treat a surgical site.

8.735.4.F. Surgical Procedures

1. A surgical procedure listed in Section 8.735.4.F.3.– 5. is a covered service for a client who:

    a. Meets the criteria at Section 8.735.4.A.1.–4.;

    b. Is 18 years of age or older;

    c. Has lived in the preferred gender role for twelve (12) continuous months;

    d. Has completed twelve (12) continuous months of hormone therapy, unless medically contraindicated;

        i) This requirement does not apply to mastectomy surgeries at Section 8.735.4.F.4.a.

    e. Has been evaluated by a licensed medical provider within the past sixty (60) days; and

    f. Has been evaluated by a licensed behavioral health provider within the past sixty (60) days.

2. Rendering surgical providers must retain the following documentation for each client:

    a. A signed statement from a licensed behavioral health provider, with whom the client has an established and ongoing relationship, demonstrating that:

        i) Criteria in Section 8.735.4.F.1.a.–d. and f. have been met; and

        ii) A post-operative care plan is in place.

    b. A signed statement from a licensed medical provider, with whom the client has an established and ongoing relationship, demonstrating that:

        i) Criteria in Section 8.735.4.F.1.a.–e. have been met; and

        ii) A post-operative care plan is in place.

3. Covered genital surgeries are limited to the following:

    a. Ovariectomy/oophorectomy

    b. Salpingo-oophorectomy

    c. Hysterectomy

    d. Vaginectomy

    e. Vulvectomy

    f. Metoidioplasty

    g. Phalloplasty

    h. Erectile prosthesis

i. Scrotoplasty

j. Testicular prostheses

k. Urethroplasty

l. Orchiectomy

m. Penectomy

n. Prostatectomy

o. Clitoroplasty

p. Vaginoplasty

q. Vulvoplasty

r. Labiaplasty

4. Covered breast/chest surgeries are limited to the following:

a. Mastectomy

b. Mammoplasty is covered when:

i) Client has completed twenty-four (24) continuous months of hormone therapy that has proven ineffective for breast development, unless medically contraindicated.

5. Pre- and post-operative services are covered when:

a. Related to a covered surgical procedure listed in Section 8.735.4.F.; and

b. Medically necessary, as defined in Section 8.076.1.8.

8.735.5 Prior Authorization

8.735.5.A. Prior authorization is required for hormone therapy services listed in Section 8.735.4.D. in accordance with pharmacy benefit prior authorization criteria at Section 8.800.7.

8.735.5.B. Prior authorization is required for covered surgeries listed in Sections 8.735.4.F.3-4.

8.735.5.C. All prior authorization requests must provide documentation demonstrating that the applicable requirements in Section 8.735.4 have been met.

8.735.6 Non-Covered Services

8.735.6.A. The following services are not covered under the transgender services benefit:

1. Any items or services excluded from coverage under Section 8.011.1.

2. Reversal of surgical procedures listed in Section 8.735.4.F.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Pharmaceutical Rule Concerning Rx Review, Section 8.800.18.C.1.a
Rule Number: MSB 19-09-18-A
Division / Contact / Phone: Pharmacy Office / Kristina Gould / 6715

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 19-09-18-A, Revision to the Medical Assistance Pharmaceutical Rule Concerning Rx Review, Section 8.800.18.C.1.a

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.800.18.C.1.a, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10)

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.800.18.C.1.a with the proposed text beginning at 8.800.18.C.1.a through the end of 8.800.18.C.1.a. This rule is effective March 2, 2020.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Pharmaceutical Rule Concerning Rx Review, Section 8.800.18.C.1.a
Rule Number: MSB 19-09-18-A
Division / Contact / Phone: Pharmacy Office / Kristina Gould / 6715

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   This rule change incorporates additional language regarding the Rx Review Program requirements. The proposed rule more concisely mirrors the State Plan and grants members the option to do a Rx Review consultation with a pharmacist over the telephone if they live outside of a reasonable travel distance from the consulting pharmacist.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   N/A

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2019);
   Section 25.5-5-507, C.R.S. (2019)

Initial Review	**[date]**	Final Adoption	**[date]**
Proposed Effective Date	**[date]**	Emergency Adoption	**[date]**

DOCUMENT #

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Pharmaceutical Rule Concerning Rx Review, Section 8.800.18.C.1.a
Rule Number: MSB 19-09-18-A
Division / Contact / Phone: Pharmacy Office / Kristina Gould / 6715

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   The classes of persons who will be affected by this proposed rule are members and pharmacists that participate in the Rx Review Program. The proposed rule will bear no cost to members or pharmacists, but instead will benefit both parties if they live outside of reasonable travel distances from one another. This proposed rule change more concisely mirrors the State Plan and allows a member and pharmacist to do a Rx Review consultation by telephone when living outside of reasonable travel distances from one another.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   Quantitatively, there are no impacts. Qualitatively, this proposed rule should create ease by promoting additional opportunities for drug consultations among members and pharmacists participating in the Rx Review Program when they live outside of reasonable travel distances from one another.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   There are no probable costs to the Department or any other agency and there is no effect on state revenues by implementing this proposed rule.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   There are no probable costs of this proposed rule. The probable benefit of this proposed rule change is that it more concisely aligns with the State Plan and offers an additional opportunity for consultations between pharmacists and members when they live outside of reasonable travel distances from one another. The probable cost of inaction is that the Department's rule will not mirror the State Plan as concisely. There are no probable benefits of inaction.

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5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   N/A

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   N/A

8.800 PHARMACEUTICALS

8.800.18 PRESCRIPTION DRUG CONSUMER INFORMATION AND TECHNICAL ASSISTANCE PROGRAM

8.800.18.C. SERVICES

1. Pharmacists participating in the program shall:

   a. Schedule a face-to-face meeting with the member within ten days of the referral. If the member is unable or refuses to participate in a face-to-face meeting or lives outside of a reasonable travel distance from the consulting pharmacist, then the pharmacist may conduct the consultation by telephone.

   b. Collect and review member drug histories.

   c. Hold face-to-face or telephonic consultations with members.

   d. Notify members that they will provide clinical recommendations to the member, the prescribing health care provider and the Department.

   e. Provide the member with information regarding:

      i) The prudent use of prescription drugs.

      ii) How to avoid dangerous drug interactions.

      iii) The appropriate use of medication to optimize therapeutic outcomes.

      iv) How to reduce the risk of adverse events, including adverse drug interactions.

2. The Department shall notify members participating in the program in writing that a pharmacist has been assigned to review the member's records and that the pharmacist will contact the member within ten days from the date of notification.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Hospital Community Benefit Accountability, Section 8.5000
Rule Number: MSB 19-09-17-A
Division / Contact / Phone: Special Financing/Nancy Dolson/3698

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 19-09-17-A, Revision to the Medical Assistance Rule concerning Hospital Community Benefit Accountability, Section 8.5000

3. This action is an adoption of: New rules

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.5000, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Insert the newly proposed text at 8.5000 with the proposed text beginning at 8.5000 through the end of 8.5003.3. This rule is effective March 2, 2020.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Hospital Community Benefit Accountability, Section 8.5000
Rule Number: MSB 19-09-17-A
Division / Contact / Phone: Special Financing/Nancy Dolson/3698

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The passage of House Bill 19-1320, Concerning Requiring Certain Health Care Providers to be Accountable in their Communities, requires hospitals to seek public feedback on community health needs and report on investments made that address community identified health needs.

   HB19-1320 requires non-profit tax-exempt general hospitals, Denver Health Medical Center, and University of Colorado Hospital to complete a community health needs assessment every three years and an annual community benefit implementation plan every year. These hospitals will be required to report this information to the Department of Health Care Policy and Financing (the Department) including community benefits, costs, and shortfalls in the preceding year.

   Each required reporting hospital must convene a public meeting at least once a year that will be used to seek feedback on the hospital's community benefit activities and the hospital's community benefit implementation plan.

   The proposed rule provides definitions of key terms and details the meeting and reporting requirements for reporting hospitals. This information will be used by the Department in its annual report to the General Assembly.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

Initial Review	**[date]**	Final Adoption	**[date]**
Proposed Effective Date	**[date]**	Emergency Adoption	**[date]**
			DOCUMENT #

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25.5-1-301 through 25.5-1-303, C.R.S. (2019);
Section 25.5-1-703, C.R.S. (2019)

Initial Review	**[date]**	Final Adoption	**[date]**
Proposed Effective Date	**[date]**	Emergency Adoption	**[date]**

DOCUMENT #

Title of Rule: Revision to the Medical Assistance Rule concerning Hospital Community Benefit Accountability, Section 8.5000
Rule Number: MSB 19-09-17-A
Division / Contact / Phone: Special Financing/Nancy Dolson/3698

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Reporting hospitals will bear the costs if any of the proposed rule. The cost is mitigated by utilizing already submitted IRS Form 990. The Department and the general public will benefit from the rule by the hospitals providing information on hospital community benefit implementation and investments that address community identified health needs.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   Reporting hospitals may experience additional administrative labor hours dedicated to the reporting and meeting requirements.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   The Department does not anticipate any effect to state revenues or any additional costs to the Department or any other agency.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   The Department does not anticipate any additional costs.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   There are no less costly or less intrusive methods.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

The statute explicitly calls for rulemaking for specific reporting requirements and for those requirements to promote uniformity. The statute also requires due dates be set in the rulemaking process.

8.5000 HOSPITAL COMMUNITY BENEFIT ACCOUNTABILITY

PURPOSE: To require hospitals to report to the Department of Health Care Policy and Financing (the Department) information on their community benefit activities, planning and investments.

8.5001 DEFINITIONS

"Community" means the community that a hospital has defined as the community that it serves pursuant to 26 CFR § 1.501(r)-(b)(3).

"Community Benefit Implementation Plan" means a plan that satisfies the requirements of an implementation strategy as described in 26 CFR § 1.501(r)-3(c).

"Community Health Center" means a federally qualified health center as defined in 42 U.S.C. sec. 1395x (aa)(4) or a rural health clinic as defined in 42 U.S.C. sec. 1395x (aa)(2).

"Community Health Needs Assessment" means a community health needs assessment that satisfies the requirements of 26 CFR § 1.501(r)-3(b).

"Community Identified Health Need" means a health need of a Community that is identified in a Community Health Needs Assessment.

"Free or Discounted Health Care Services" means health care services provided by the hospital to persons who meet the hospital's criteria for financial assistance and are unable to pay for all or a portion of the services, or physical or behavioral health care services funded by the hospital but provided without charge to patients by other organizations in the Community. Free or Discounted Health Care Services does not include the following:

1. Services reimbursed through the Colorado Indigent Care Program (CICP),

2. Bad debt or uncollectable amounts owed that the hospital recorded as revenue but wrote off due to a patient's failure to pay, or the cost of providing care to such patients,

3. The difference between the cost of care provided under Medicaid or other means-tested government programs or under Medicare and the revenue derived therefrom,

4. Self-pay or prompt pay discounts, or

5. Contractual adjustments with any third-party payers.

"Health System" means a larger corporation or organizational structure that owns, contains, or operates more than one hospital.

"Programs that Address Health Behaviors or Risk" means programs funded by the hospital and provided by the hospital or other Community organizations that provide education, mentorship, or other supports that help people make or maintain healthy life choices or manage chronic disease, including addiction prevention and treatment programs, suicide prevention programs and mental health treatment, programs to prevent tobacco use, disease management programs, nutrition education programs, programs that support maternal health, including screening, referral and treatment for perinatal and postpartum depression and anxiety, and healthy birth outcomes, and programs that help seniors and people with disabilities live as independently as possible in the Community.

"Programs that Address the Social Determinants of Health" means funding or in-kind programs or services that improve social, economic, and environmental conditions that impact health in the

Community. Social and economic conditions that impact health include education; employment; income; family and social support; and Community safety. Environmental conditions that impact health include air and water quality, housing, and transit. Programs that Address the Social Determinants of Health include but are not limited to the following:

1. Job training programs,

2. Support for early childhood and elementary, middle, junior-high, and high school education,

3. Programs that increase access to nutritious food and safe housing,

4. Medical Legal Partnerships, and

5. Community-building activities that could be included in Part II of Schedule H of the Form 990.

"Reporting Hospital" means

1. A hospital licensed as a general hospital pursuant to Part 1 of Article 3 of Title 25 of the Colorado Revised Statutes and exempt from Federal taxation pursuant to Section 501(c)(3) of the Federal Internal Revenue code, but not including a general hospital that is federally certified or undergoing federal certification as a long-term care hospital pursuant to 42 CFR § 412.23(e) or that is federally certified or undergoing federal certification as a critical access hospital pursuant to 42 CFR § 485 Subpart F,

2. A hospital established pursuant to § 25-29-103 C.R.S., or

3. A hospital established pursuant to § 23-21-503 C.R.S.

"Safety Net Clinic" means a Community clinic licensed or certified by the Department of Public Health and Environment pursuant to Section § 25-1.5-103 (1)(a)(I) or (1)(a)(II), C.R.S.

8.5002 HOSPITAL REQUIREMENTS

8.5002.A PUBLIC MEETING REQUIREMENTS

1. Each Reporting Hospital shall convene a public meeting at least once per year to seek feedback regarding the hospital's Community benefit activities during the previous year and the hospital's Community Benefit Implementation Plan for the upcoming year.

2. Reporting Hospitals may convene a joint public meeting with one or more other participating hospitals that share some or all of the hospital's Community.

3. Reporting Hospitals may conduct a public meeting that meets other purposes, such as the Community Health Needs Assessment requirements under 26 CFR § 1.501(r)-3 or other Community engagement efforts as long as the public meeting meets the minimum requirements in this section.

4. Each Reporting Hospital shall invite, at a minimum, representatives from the following entities to participate in the meeting if any such entities operate in the hospital's Community:

    a. Local public health agencies,

    b. Local chambers of commerce and economic development organizations,

c. Local health care consumer organizations,

d. School districts,

e. County governments,

f. City and town governments,

g. Community Health Center,

h. Certified rural health clinics or primary care clinics located in a county that has been designated as a rural or frontier county,

i. Area agencies on aging,

j. Safety Net Clinics, and

k. Health care consumer advocacy organizations.

5. Each Reporting Hospital shall invite, at a minimum, representatives from the following agencies to participate in the meeting:

a. The Department of Health Care Policy and Financing,

b. The Department of Public Health and Environment,

c. The Department of Human Services,

d. The Colorado Commission on Higher Education,

e. The Office of Saving People Money on Health Care, and

f. The Division of Insurance within the Department of Regulatory Agencies

6. Each Reporting Hospital shall invite the general public to the annual meeting and shall issue such invitation in an advertisement placed in each major newspaper published in the hospital's Community.

a. Reporting Hospitals shall undertake the following efforts to promote broad Community notification and participation in the public meetings and to make meetings accessible:

i. Collaborate with Community-based organizations and other Community partners to distribute invitations to the public,

ii. Advertise that American Sign Language services and interpretation services for individuals with limited English proficiency are available upon request,

iii. Upon request, provide American Sign Language services and, for individuals with limited English proficiency, provide language and interpretation services to ensure meaningful access such as those described in 45 C.F.R. § 92.201.

b. Reporting Hospitals may also undertake additional activities including but not limited to the following:

i. Advertise the public meeting in additional newspapers in the Community, including those that are published in languages other than English,

ii. Advertise the public meeting via radio stations broadcast in the Community, including radio stations that broadcast in languages other than English,

iii. Schedule the public meeting outside of the typical workday hours, and

iv. Provide reimbursement for transportation and childcare expenses incurred for the purposes of participating in the public meeting.

8.5002.B HOSPITAL REPORTING REQUIREMENTS

1. Each Reporting Hospital shall complete a Community Health Needs Assessment on or before July 1, 2020, and then on or before July 1 at least every three (3) years thereafter.

   a. Acquired or new hospitals must complete their first Community Health Needs Assessment as described under 26 CFR § 1.501(r)-3(d).

2. Each Reporting Hospital shall complete a Community Benefit Implementation Plan that addresses the needs described in the Community Health Needs Assessment on or before July 1, 2020, and then on or before July 1 every year thereafter.

3. Each Reporting Hospital shall submit to the Department on or before July 1, 2020 a report on its most recent public meeting held to satisfy its Community Health Needs Assessment requirements under 26 CFR § 1.501(r)-3.

4. Beginning July 1, 2021 and then on or before July 1 every year thereafter each Reporting Hospital shall submit to the Department a report on the public meetings held during the previous twelve months.

5. Each public meeting report shall include but is not limited to the following:

   a. Date, time, and location of the meeting,

   b. Outreach efforts to ensure broad Community participation and accessibility,

   c. Individuals and organizations, including the populations served by the organizations, invited to the meeting,

   d. A list of individual meeting attendees and organizations represented,

   e. Meeting agenda,

   f. A summary of the meeting discussion, and

   g. Actions taken as a result of feedback from meeting participants.

6. Each Reporting Hospital shall submit to the Department on or before July 1, 2020 and then on or before July 1 every year thereafter a report on Community benefits, costs, and shortfalls that must include the following:

a. The most recent Community Health Needs Assessment.

b. The most recent Community Benefit Implementation Plan for the coming year.

c. A copy of the most recent submitted form 990 to the Federal Internal Revenue Service including Schedule H.

i. Reporting Hospitals that are part of a Health System or other corporate structure that file a consolidated form 990 to the Federal Internal Revenue Service shall provide information that was included in Parts I, II, III, and V of Schedule H of form 990 for each Reporting Hospital separately.

ii. Reporting Hospitals not required to submit Schedule H of the form 990 to the Federal Internal Revenue Service shall complete Parts I, II, III, and V of Schedule H of form 990 available on the Federal Internal Revenue Service's website.

d. A description of investments made by the Reporting Hospital or a related entity that were included in Parts I, II, and III of Schedule H of form 990 that includes at a minimum the following:

i. Cost of the investment.

ii. Indicate if the investment addressed a Community Identified Health Need.

iii. For any investment that addressed a Community Identified Health Need identify the following applicable categories:

1. Free or Discounted Health Care Services,

2. Programs that Address Health Behaviors or Risk, and

3. Programs that Address the Social Determinants of Health.

iv. For any investment that addressed a Community Identified Health Need describe available evidence that shows how the investment improves Community health outcomes.

e. The Reporting Hospital's total expenses included in Line 18 of Section 1 of the submitted form 990. Reporting Hospitals not required to submit form 990 to the Federal Internal Revenue Service shall complete Line 18 of Section 1 of form 990 available on the Federal Internal Revenue Service's website.

f. The Reporting Hospital's revenue less expenses included in Line 19 of Section 1 of the submitted form 990. Reporting Hospitals not required to submit form 990 to the Federal Internal Revenue Service shall complete Line 19 of Section 1 of form 990 available on the Federal Internal Revenue Service's website.

7. In the event that the due date falls on a weekend or state holiday the due date shall fall on the next business day.

8. Each Reporting Hospital shall post the report to their public website and submit to the Department the website address where the report has been posted.

9. A hospital licensed as a general hospital pursuant to part 1 of Article 3 of Title 25 that is not a Reporting Hospital may report on Community benefits, costs, and shortfalls consistent with this section.

8.5003 DEPARTMENT REQUIREMENTS

1. The Department shall develop a website for each Reporting Hospital to submit their reports and ensure the reports are available to the public.

2. As part of the report authorized in Section 25.5-4-402.8, C.R.S., the Department shall submit to the General Assembly a summary report of the hospital reports submitted that includes the following:

    a. Community benefits as defined in Part I and Part II of the Schedule H as a percentage of total expenses.

    b. The amount each Reporting Hospital invested in the following areas, including that amount as a percentage of total Community benefit spending in Part I and II of Schedule H:

        i. Free or Discounted Health Care Services that addressed Community identified health needs,

        ii. Programs that Address Health Behaviors or Risks,

        iii. Programs that Address Social Determinants of Health, and

        iv. All services and programs that addressed Community identified health needs.

    c. Summary of each Reporting Hospital's investments and evidence that that shows how the investment improves Community health outcomes.

    d. Legislative recommendations for the General Assembly.

3. The Department shall post the reports submitted to the General Assembly to a public web page created solely for this purpose.

DO NOT PUBLSIH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning In-Home Support Services Definitions, Section 8.552.1
Rule Number: MSB 19-10-25-A
Division / Contact / Phone: Benefits and Services Management / Erin Thatcher / 303-866-5788

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name:	Health Care Policy and Financing / Medical Services Board
2. Title of Rule:	MSB 19-10-25-A, Revision to the Medical Assistance Rule concerning In-Home Support Services Definitions, Section 8.552.1
3. This action is an adoption of:	an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.552.1, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)?	Yes
If yes, state effective date:	11/08/2019
Is rule to be made permanent? (If yes, please attach notice of hearing).	No

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.552.1 wit the proposed text beginning at 8.552.1.B through the end of 8.552.1.C. This rule is effective March 2, 2020.

*to be completed by MSB Board Coordinator

DO NOT PUBLSIH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning In-Home Support Services Definitions, Section 8.552.1
Rule Number: MSB 19-10-25-A
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STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   This revision of the IHSS definitions is required per the Office of Legislative Legal Services (OLLS) to ensure the definitions in rule are consistent with those in statute and the rules are compliant with Title 25.5, Article 6, Part 12, C.R.S.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2019);
   Section 25.5-6-1201, C.R.S. (2019)

Initial Review — Final Adoption **01/10/20**
Proposed Effective Date **03/02/20** — Emergency Adoption

DOCUMENT #04

DO NOT PUBLSIH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning In-Home Support Services Definitions, Section 8.552.1
Rule Number: MSB 19-10-25-A
Division / Contact / Phone: Benefits and Services Management / Erin Thatcher / 303-866-5788

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   The rule amendment is required to ensure compliance with Title 25.5, Article 6, Part 12, C.R.S. There are no individuals that will be impacted by the proposed changes.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   There will not be an impact on the delivery of services.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   There are no costs associated with the proposed rule amendment.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   Not applicable; the Department must revise the definitions per the Office of Legislative Legal Services.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   The Department must revise the definitions per the Office of Legislative Legal Services.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   The Department must revise the definitions per the Office of Legislative Legal Services.

8.552 IN-HOME SUPPORT SERVICES

8.552.1 DEFINITIONS

A. Assessment means a comprehensive evaluation with the client seeking services and appropriate collaterals (such as family members, advocates, friends and/or caregivers) conducted by the Case Manager, with supporting diagnostic information from the client's medical provider to determine the client's level of functioning, service needs, available resources, and potential funding sources. Case Managers shall use the Department prescribed tool to complete assessments.

B. Attendant means a person who is directly employed by an In-Home Support Services (IHSS) Agency to provide IHSS ~~to a client and meets the qualifications as defined at 10 C.C.R 2505-10, Section 8.552.6.K~~. A family member, including a spouse, may be an Attendant.

C. Authorized Representative means an individual designated by the client, or by the parent or guardian of the client ~~receiving services~~, if appropriate, who has the judgment and ability to assist the client in acquiring and receiving services ~~as defined in Section 25.5-6-1202, C.R.S.~~ under Title 25.5, Article 6, Part 12, C.R.S. The authorized representative shall not be the eligible person's service provider.

D. Care Plan means a written plan of care developed between the client or the client's Authorized Representative, IHSS Agency and Case Management Agency that is authorized by the Case Manager.

E. Case Management Agency (CMA) means a public or private entity that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community Based Services waivers pursuant to §§ 25.5-10-209.5 and 25.5-6- 106, C.R.S., and has a current provider participation agreement with the Department.

F. Case Manager means an individual employed by a Case Management Agency who is qualified to perform the following case management activities: determination of an individual client's functional eligibility for the Home and Community Based Services (HCBS) waivers, development and implementation of an individualized and person-centered care plan for the client, coordination and monitoring of HCBS waiver services delivery, evaluation of service effectiveness, and the periodic reassessment of such client's needs.

G. Extraordinary Care means a service which exceeds the range of care a Family Member would ordinarily perform in a household on behalf of a person without a disability or chronic illness of the same age, and which is necessary to assure the health and welfare of the client and avoid institutionalization.

H. Family Member means any person related to the client by blood, marriage, adoption, or common law as determined by a court of law.

I. Health Maintenance Activities means those routine and repetitive skilled health-related tasks, which are necessary for health and normal bodily functioning, that an individual with a disability would carry out if they were physically able, or that would be carried out by Family Members or friends if they were available. These activities include skilled tasks typically performed by a Certified Nursing Assistant (CNA) or licensed nurse that do not require the clinical assessment and judgement of a licensed nurse.

J. Homemaker Services means general household activities provided by an Attendant in the client's primary living space to maintain a healthy and safe home environment for a client, when the person ordinarily responsible for these activities is absent or unable to manage these tasks.

K. Inappropriate Behavior means documented verbal, sexual or physical threats or abuse committed by the client or Authorized Representative toward Attendants, Case Managers, or the IHSS Agency.

L. Independent Living Core Services means services that advance and support the independence of individuals with disabilities and to assist those individuals to live outside of institutions. These services include but are not limited to: information and referral services, independent living skills training, peer and cross-disability peer counseling, individual and systems advocacy, transition services or diversion from nursing homes and institutions to home and community-based living, or upon leaving secondary education.

M. In-Home Support Services (IHSS) means services that are provided in the home and in the community by an Attendant under the direction of the client or client's Authorized Representative, including Health Maintenance Activities and support for activities of daily living or instrumental activities of daily living, Personal Care services and Homemaker services.

N. In-Home Support Services (IHSS) Agency means an agency that is certified by the Colorado Department of Public Health and Environment, enrolled in the Medicaid program and provides Independent Living Core Services.

O. Licensed Health Care Professional means a state-licensed Registered Nurse (RN) who contracts with or is employed by the IHSS Agency,

P. Licensed Medical Professional means the primary care provider of the client, who possesses one of the following licenses: Physician (MD/DO), Physician Assistant (PA) and Advanced Practicing Nurse (APN) as governed by the Colorado Medical Practice Act and the Colorado Nurse Practice Act.

Q. Personal Care means services which are furnished to an eligible client meet the client's physical, maintenance and supportive needs, when those services are not skilled Personal Care, do not require the supervision of a nurse, and do not require physician's orders.

R. Prior Authorization Request (PAR) means the Department prescribed process used to authorize HCBS waiver services before they are provided to the client, pursuant to 10 C.C.R. 2505-10, Section 8.485.90.

8.552.2 ELIGIBILITY

8.552.2.A. To be eligible for IHSS the client shall meet the following eligibility criteria:

1. Be enrolled in a Medicaid program approved to offer IHSS.

2. Provide a signed Physician Attestation of Consumer Capacity form at enrollment and following any change in condition stating that the client has sound judgment and the ability to self-direct care. If the client is in unstable health with an unpredictable progression or variation of disability or illness, the Physician Attestation of Consumer Capacity form shall also include a recommendation regarding whether additional supervision is necessary and if so, the amount and scope of supervision requested.

3. Clients who elect or are required to have an Authorized Representative must appoint an Authorized Representative who has the judgment and ability to assist the client in acquiring and using services, or

a. Obtain assistance from an IHSS Agency that is able and willing to support the client as necessary to participate in IHSS.

4. Demonstrate a current need for covered Attendant support services.

8.552.2.B. IHSS eligibility for a client will end if:

1. The client is no longer enrolled in a Medicaid program approved to offer IHSS.

2. The client's medical condition deteriorates causing an unsafe situation for the client or the Attendant as determined by the client's Licensed Medical Professional.

3. The client refuses to designate an Authorized Representative or receive assistance from an IHSS Agency when the client is unable to direct their own care as documented by the client's Licensed Medical Professional on the Physician Attestation of Consumer Capacity form.

4. The client provides false information or false records.

5. The client no longer demonstrates a current need for Attendant support services.

8.552.3 COVERED SERVICES

8.552.3.A. Services are for the benefit of the client. Services for the benefit of other persons are not reimbursable.

8.552.3.B. Services available for eligible adults:

1. Homemaker

2. Personal Care

3. Health Maintenance Activities.

8.552.3.C. Services available for eligible children:

1. Health Maintenance Activities.

8.552.3.D. Service Inclusions:

1. Homemaker:

a. Routine housekeeping such as: dusting, vacuuming, mopping, and cleaning bathroom and kitchen areas;

b. Meal preparation;

c. Dishwashing;

d. Bed making;

e. Laundry;

f. Shopping for necessary items to meet basic household needs.

2. Personal Care:

a. Eating/feeding which includes assistance with eating by mouth using common eating utensils such as spoons, forks, knives, and straws;

b. Respiratory assistance with cleaning or changing oxygen equipment tubes, filling distilled water reservoirs, and moving a cannula or mask to or from the client's face;

c. Preventative skin care when skin is unbroken, including the application of non-medicated/non-prescription lotions, sprays and/or solutions, and monitoring for skin changes.

d. Bladder/Bowel Care:

i) Assisting client to and from the bathroom;

ii) Assistance with bed pans, urinals, and commodes;

iii) Changing incontinence clothing or pads;

iv) Emptying Foley or suprapubic catheter bags, but only if there is no disruption of the closed system;

v) Emptying ostomy bags;

vi) Perineal care.

e. Personal hygiene:

i) Bathing including washing, shampooing;

ii) Grooming;

iii) Shaving with an electric or safety razor;

iv) Combing and styling hair;

v) Filing and soaking nails;

vi) Basic oral hygiene and denture care.

f. Dressing assistance with ordinary clothing and the application of non-prescription support stockings, braces and splints, and the application of artificial limbs when the client is able to assist or direct.

g. Transferring a client when the client has sufficient balance and strength to reliably stand and pivot and assist with the transfer. Adaptive and safety equipment may be used in transfers, provided that the client and Attendant are

fully trained in the use of the equipment and the client can direct and assist with the transfer.

h. Mobility assistance when the client has the ability to reliably balance and bear weight or when the client is independent with an assistive device.

i. Positioning when the client is able to verbally or non-verbally identify when their position needs to be changed including simple alignment in a bed, wheelchair, or other furniture.

j. Medication Reminders when medications have been preselected by the client, a Family Member, a nurse or a pharmacist, and the medications are stored in containers other than the prescription bottles, such as medication minders, and:

i) Medication minders are clearly marked with the day, time, and dosage and kept in a way as to prevent tampering;

ii) Medication reminding includes only inquiries as to whether medications were taken, verbal prompting to take medications, handing the appropriately marked medication minder container to the client and opening the appropriately marked medication minder if the client is unable to do so independently.

k. Cleaning and basic maintenance of durable medical equipment.

l. Protective oversight when the client requires supervision to prevent or mitigate disability related behaviors that may result in imminent harm to people or property.

m. Accompanying includes going with the client, as indicated on the care plan, to medical appointments and errands such as banking and household shopping. Accompanying the client may include providing one or more personal care services as needed during the trip. Attendant may assist with communication, documentation, verbal prompting, and/or hands-on assistance when the task cannot be completed without the support of the attendant.

3. Health Maintenance Activities:

a. Skin care, when the skin is broken, or a chronic skin condition is active and could potentially cause infection, and the client is unable to apply prescription creams, lotions, or sprays independently due to illness, injury or disability. Skin care may include wound care, dressing changes, application of prescription medicine, and foot care for people with diabetes when directed by a Licensed Medical Professional.

b. Hair care including shampooing, conditioning, drying, and combing when performed in conjunction with health maintenance level bathing, dressing, or skin care. Hair care may be performed when:

i) Client is unable to complete task independently;

ii) Application of a prescribed shampoo/conditioner which has been dispensed by a pharmacy; or

iii) Client has open wound(s) or neck stoma(s).

c. Nail care in the presence of medical conditions that may involve peripheral circulatory problems or loss of sensation; includes soaking, filing and trimming.

d. Mouth care performed when health maintenance level skin care is required in conjunction with the task, or:

i) There is injury or disease of the face, mouth, head or neck;

ii) In the presence of communicable disease;

iii) When the client is unable to participate in the task;

iv) Oral suctioning is required;

v) There is decreased oral sensitivity or hypersensitivity;

vi) Client is at risk for choking and aspiration.

e. Shaving performed when health maintenance level skin care is required in conjunction with the shaving, or:

i) The client has a medical condition involving peripheral circulatory problems;

ii) The client has a medical condition involving loss of sensation;

iii) The client has an illness or takes medications that are associated with a high risk for bleeding;

iv) The client has broken skin at/near shaving site or a chronic active skin condition.

f. Dressing performed when health maintenance level skin care or transfers are required in conjunction with the dressing, or;

i) The client is unable to assist or direct care;

ii) Assistance with the application of prescribed anti-embolic or pressure stockings is required;

iii) Assistance with the application of prescribed orthopedic devices such as splints, braces, or artificial limbs is required.

g. Feeding is considered a health maintenance task when the client requires health maintenance level skin care or dressing in conjunction with the task, or:

i) Oral suctioning is needed on a stand-by or intermittent basis;

ii) The client is on a prescribed modified texture diet;

iii) The client has a physiological or neurogenic chewing or swallowing problem;

iv) Syringe feeding or feeding using adaptive utensils is required;

v) Oral feeding when the client is unable to communicate verbally, non-verbally or through other means.

h. Exercise including passive range of motion. Exercises must be specific to the client's documented medical condition and require hands on assistance to complete.

i. Transferring a client when they are not able to perform transfers due to illness, injury or disability, or:

i) The client lacks the strength and stability to stand, maintain balance or bear weight reliably;

ii) The client has not been deemed independent with adaptive equipment or assistive devices by a Licensed Medical Professional;

iii) The use of a mechanical lift is needed.

j. Bowel care performed when health maintenance level skin care or transfers are required in conjunction with the bowel care, or:

i) The client is unable to assist or direct care;

ii) Administration of a bowel program including but not limited to digital stimulation, enemas, or suppositories;

iii) Care of a colostomy or ileostomy that includes emptying and changing the ostomy bag and application of prescribed skin care products at the site of the ostomy.

k. Bladder care performed when health maintenance level skin care or transfers are required in conjunction with bladder care, or;

i) The client is unable to assist or direct care;

ii) Care of external, indwelling and suprapubic catheters;

iii) Changing from a leg to a bed bag and cleaning of tubing and bags as well as perineal care.

l. Medical management as directed by a Licensed Medical Professional to routinely monitor a documented health condition, including but not limited to: blood pressures, pulses, respiratory rate, blood sugars, oxygen saturations, intravenous or intramuscular injections

m. Respiratory care:

i) Postural drainage

ii) Cupping

iii) Adjusting oxygen flow within established parameters

iv) Suctioning of mouth and nose

v) Nebulizers

vi) Ventilator and tracheostomy care

vii) Assistance with set-up and use of respiratory equipment

n. Bathing is considered a health maintenance task when the client requires health maintenance level skin care, transfers or dressing in conjunction with bathing.

o. Medication Assistance, which may include setup, handling and assisting the client with the administration of medications. The IHSS Agency's Licensed Health Care Professional must validate Attendant skills for medication administration and ensure that the completion of task does not require clinical judgement or assessment skills.

p. Accompanying includes going with the client, as necessary on the care plan, to medical appointments and errands such as banking and household shopping. Accompanying the client also may include providing one or more health maintenance tasks as needed during the trip. Attendant may assist with communication, documentation, verbal prompting and/or hands on assistance when the task cannot be completed without the support of the Attendant.

q. Mobility assistance is considered a health maintenance task when health maintenance level transfers are required in conjunction with the mobility assistance, or:

i) The client is unable to assist or direct care;

ii) When hands-on assistance is required for safe ambulation and the client is unable to maintain balance or to bear weight reliably due to illness, injury, or disability; and/or

iii) the client has not been deemed independent with adaptive equipment or assistive devices ordered by a Licensed Medical Professional.

r. Positioning includes moving the client from the starting position to a new position while maintaining proper body alignment, support to a client's extremities and avoiding skin breakdown. May be performed when health maintenance level skin care is required in conjunction with positioning, or;

i) the client is unable to assist or direct care, or

ii) the client is unable to complete task independently.

8.552.4 CLIENT AND AUTHORIZED REPRESENTATIVE PARTICIPATION AND SELF-DIRECTION

8.552.4.A. A client or their Authorized Representative may self-direct the following aspects of service delivery:

1. Present a person(s) of their own choosing to the IHSS Agency as a potential Attendant. The client must have adequate Attendants to assure compliance with all tasks in the Care Plan.

2. Train Attendant(s) to meet their needs.

3. Dismiss Attendants who are not meeting their needs.

4. Schedule, manage, and supervise Attendants with the support of the IHSS Agency.

5. Determine, in conjunction with the IHSS Agency, the level of in-home supervision as recommended by the client's Licensed Medical Professional.

6. Transition to alternative service delivery options at any time. The Case Manager shall coordinate the transition and referral process.

7. Communicate with the IHSS Agency and Case Manager to ensure safe, accurate and effective delivery of services.

8. Request a reassessment, as described at Section 8.393.2.D, if level of care or service needs have changed.

8.552.4.B. An Authorized Representative is not allowed to be reimbursed for IHSS Attendant services for the client they represent.

8.552.4.C. If the client is required to or elects to have an Authorized Representative, the Authorized Representative shall meet the requirements:

1. Must be at least 18 years of age.

2. Must have known the client for at least two years. For children under the age of two, the Authorized Representative must have known the child for the duration of their life.

3. Has not been convicted of any crime involving exploitation, abuse, neglect, or assault on another person.

8.552.4.D. The Authorized Representative must attest to the above requirement on the Authorized Representative Designation for In-Home Support Services (IHSS) form.

8.552.4.E. IHSS clients who personally require an Authorized Representative may not serve as an Authorized Representative for another IHSS client.

8.552.4.F. The client and their Authorized Representative must adhere to IHSS Agency policies and procedures.

8.552.5 IHSS AGENCY ELIGIBILITY

8.552.5.A. The IHSS Agency must be a licensed home care agency. The IHSS Agency shall be in compliance with all requirements of their certification and licensure, in addition to requirements outlined at Section 8.487.

8.552.5.B. The provider agreement for an IHSS Agency may be terminated, denied, or non-renewed pursuant to Section 8.076.5.

8.552.5.C. Administrators or managers as defined at 6 CCR 1011-1 Chapter 26 shall satisfactorily complete the Department authorized training on IHSS rules and regulations prior to Medicaid certification and annually thereafter.

8.552.6 IHSS AGENCY RESPONSIBILITIES

8.552.6.A. The IHSS Agency shall assure and document that all clients are provided the following:

1. Independent Living Core Services

    a. An IHSS Agency must provide a list of the full scope of Independent Living Core Services provided by the agency to each client on an annual basis. The IHSS Agency must keep a record of each client's choice to utilize or refuse these services, and document services provided

2. Attendant training, oversight and supervision by a licensed health care professional.

3. The IHSS agency shall provide 24-hour back-up service for scheduled visits to clients at any time an Attendant is not available. At the time the Care Plan is developed the IHSS Agency shall ensure that adequate staffing is available. Staffing must include backup Attendants to ensure necessary services will be provided in accordance with the Care Plan.

8.552.6.B. The IHSS Agency shall adhere to the following:

1. If the IHSS Agency admits clients with needs that require care or services to be delivered at specific times or parts of day, the IHSS Agency shall ensure qualified staff in sufficient quantity are employed by the agency or have other effective back-up plans to ensure the needs of the client are met.

2. The IHSS Agency shall only accept clients for care or services based on a reasonable assurance that the needs of the client can be met adequately by the IHSS Agency in the individual's temporary or permanent home or place of residence.

    a. There shall be documentation in the Care Plan or client record of the agreed upon days and times of services to be provided based upon the client's needs that is updated at least annually.

3. If an IHSS Agency receives a referral of a client who requires care or services that are not available at the time of referral, the IHSS Agency shall advise the client or their Authorized Representative and the Case Manager of that fact.

    a. The IHSS Agency shall only admit the client if the client or their Authorized Representative and Case Manager agree the recommended services can be delayed or discontinued.

4. The IHSS Agency shall ensure orientation is provided to clients or Authorized Representatives who are new to IHSS or request re-orientation through The Department's prescribed process. Orientation shall include instruction in the philosophy, policies and procedures of IHSS and information concerning client rights and responsibilities.

5. The IHSS Agency will keep written service notes documenting the services provided at each visit.

8.552.6.C. The IHSS Agency is the legal employer of a client's Attendants and must adhere to all requirements of federal and state law, and to the rules, regulations, and practices as prescribed by The Department.

8.552.6.D. The IHSS Agency shall assist all clients in interviewing and selecting an Attendant when requested and maintain documentation of the IHSS Agency's assistance and/or the client's refusal of such assistance.

8.552.6.E. The IHSS Agency will complete an intake assessment following referral from the Case Manager. The IHSS Agency will develop a Care Plan in coordination with the Case Manager and client. Any proposed services outlined in the Care Plan that may result in an increase in authorized services and units must be submitted to the Case Manager for review. The Care Plan must be approved prior to start of services.

8.552.6.F. The IHSS Agency shall ensure that a current Care Plan is in the client's record, and that Care Plans are updated with the client at least annually or more frequently in the event of a client's change in condition. The IHSS Agency will send the Care Plan to the Case Manager for review and approval.

1. The Care Plan will include a statement of allowable Attendant hours and a detailed listing of frequency, scope and duration of each service to be provided to the client for each day and visit. The Care Plan shall be signed by the client or the client's Authorized Representative and the IHSS Agency.

a. Secondary or contiguous tasks must be outlined on the care plan as described in Section 8.552.8.F.

2. In the event of the observation of new symptoms or worsening condition that may impair the client's ability to direct their care, the IHSS Agency, in consultation with the client or their Authorized Representative and Case Manager, shall contact the client's Licensed Medical Professional to receive direction as to the appropriateness of continued care. The outcome of that consultation shall be documented in the client's revised Care Plan, with the client and/or Authorized Representative's input and approval. The IHSS Agency will submit the revised Care Plan to the Case Manager for review and approval.

8.552.6.G. The IHSS Agency's Licensed Health Care Professional is responsible for the following activities:

1. Administer a skills validation test for Attendants who will perform Health Maintenance Activities. Skills validation for all assigned tasks must be completed prior to service delivery unless postponed by the client or Authorized Representative to prevent interruption in services. The reason for postponement shall be documented by the IHSS in the client's file. In no event shall the skills validation be postponed for more than thirty (30) days after services begin to prevent interruption in services.

2. Verify and document Attendant skills and competency to perform IHSS and basic client safety procedures.

3. Counsel Attendants and staff on difficult cases and potentially dangerous situations.

4. Consult with the client, Authorized Representative or Attendant in the event a medical issue arises.

5. Investigate complaints and critical incidents within ten (10) calendar days as defined in Section 8.487.15.

6. Verify the Attendant follows all tasks set forth in the Care Plan.

7. Review the Care Plan and Physician Attestation for Consumer Capacity form upon initial enrollment, following any change of condition, and upon the request of the client, their Authorized Representative, or the Case Manager.

8. Provide in-home supervision for the client as recommended by their Licensed Medical Professional and as agreed upon by the client or their Authorized Representative.

8.552.6.H. At the time of enrollment and following any change of condition, the IHSS Agency will review recommendations for supervision listed on the Physician Attestation of Consumer Capacity form. This review of recommendations shall be documented by the IHSS Agency in the client record.

1. The IHSS Agency shall collaborate with the client or client's Authorized Representative to determine the level of supervision provided by the IHSS Agency's Licensed Health Care Professional beyond the requirements set forth at Section 25.5-6-1203, C.R.S.

2. The client may decline recommendations by the Licensed Medical Professional for in-home supervision. The IHSS Agency must document this choice in the client record and notify the Case Manager. The IHSS Agency and their Licensed Health Care Professional, Case Manager, and client or their Authorized Representative shall discuss alternative service delivery options and the appropriateness of continued participation in IHSS.

8.552.6.I. The IHSS Agency shall assure and document that all Attendants have received training in the delivery of IHSS prior to the start of services. Attendant training shall include:

1. Development of interpersonal skills focused on addressing the needs of persons with disabilities.

2. Overview of IHSS as a service-delivery option of consumer direction.

3. Instruction on basic first aid administration.

4. Instruction on safety and emergency procedures.

5. Instruction on infection control techniques, including universal precautions.

6. Mandatory reporting and critical incident reporting procedures.

7. Skills validation test for unskilled tasks assigned on the care plan.

8.552.6.J. The IHSS Agency shall allow the client or Authorized Representative to provide individualized Attendant training that is specific to their own needs and preferences.

8.552.6.K. With the support of the IHSS Agency, Attendants must adhere to the following:

1. Must be at least 18 years of age and demonstrate competency in caring for the client to the satisfaction of the client or Authorized Representative.

2. May be a Family Member subject to the reimbursement and service limitations in Section 8.552.8.

3. Must be able to perform the assigned tasks on the Care Plan.

4. Shall not, in exercising their duties as an IHSS Attendant, represent themselves to the public as a licensed nurse, a certified nurse's aide, a licensed practical or professional nurse, a registered nurse or a registered professional nurse as defined in Section 25.5-6-1203, C.R.S.

5. Shall not have had their license as a nurse or certified nurse aide suspended or revoked or their application for such license or certification denied.

8.552.6.L. The IHSS Agency shall provide functional skills training to assist clients and their Authorized Representatives in developing skills and resources to maximize their independent living and personal management of health care.

8.552.7 CASE MANAGEMENT AGENCY RESPONSIBILITIES

8.552.7.A. The Case Manager shall provide information and resources about IHSS to eligible clients, including a list of IHSS Agencies in their service area and an introduction to the benefits and characteristics of participant-directed programs.

8.552.7.B. The Case Manager will initiate a referral to the IHSS Agency of the client or Authorized Representative's choice, including an outline of approved services as determined by the Case Manager's most recent assessment. The referral must include the Physician Attestation, assessment information, and other pertinent documentation to support the development of the Care Plan.

8.552.7.C. The Case Manager must ensure that the following forms are completed prior to the approval of the Care Plan or start of services:

1. The Physician Attestation of Consumer Capacity form shall be completed upon enrollment and following any change in condition.

2. If the client requires an Authorized Representative, the Authorized Representative Designation for In-Home Support Services (IHSS) form or In-Home Support Services (IHSS) Client and Provider Agency Responsibilities form must be completed.

8.552.7.D. Upon the receipt of the Care Plan, the Case Manager shall:

1. Review the Care Plan within five business days of receipt to ensure there is no disruption or delay in the start of services.

2. Ensure all required information is in the client's Care Plan and that services are appropriate given the client's medical or functional condition. If needed, request additional information from the client, their Authorized Representative, the IHSS Agency, or Licensed Medical Professional regarding services requested.

3. Review the Care Plan to ensure there is delineation for all services to be provided; including frequency, scope, and duration.

4. Review the Licensed Medical Professional's recommendation for in-home supervision as requested on the Physician Attestation of Consumer Capacity form. The Case Manager will document the status of recommendations and provide resources for services outside the scope of the client's eligible benefits.

5. Collaborate with the client or their Authorized Representative and the IHSS Agency to establish a start date for services. The Case Manager shall discontinue any services that are duplicative with IHSS.

6. Authorize cost-effective and non-duplicative services via the PAR. Provide a copy of the PAR to the IHSS Agency in accordance with procedures established by The Department prior to the start of IHSS services.

7. Work collaboratively with the IHSS Agency, client, and their Authorized Representative to mediate Care Plan disputes following The Department's prescribed process.

    a. Case Manager will complete the Notice Services Status (LTC-803) and provide the client or the Authorized Representative with the reasons for denial of requested service frequency or duration, information about the client's rights to fair hearing, and appeal procedures.

8.552.7.E. The Case Manager shall ensure cost-effectiveness and non-duplication of services by:

1. Documenting the discontinuation of previously authorized agency-based care, including Homemaker, Personal Care, and long-term home health services that are being replaced by IHSS.

2. Documenting and justifying any need for additional in-home services including but not limited to acute or long-term home health services, hospice, traditional HCBS services, and private duty nursing.

    a. A client may receive non-duplicative services from multiple Attendants or agencies if appropriate for the client's level of care and documented service needs.

3. Ensuring the client's record includes documentation to substantiate all Health Maintenance Activities on the Care Plan and requesting additional information as needed.

4. Coordinating transitions from a hospital, nursing facility, or other agency to IHSS. Assisting client with transitions from IHSS to alternate services if appropriate.

5. Collaborating with the client or their Authorized Representative and the IHSS Agency in the event of any change in condition. The Case Manager shall request an updated Physician Attestation of Consumer Capacity form. The Case Manager may revise the Care Plan as appropriate given the client's condition and functioning.

6. Completing a reassessment if requested by the client as described at Section 8.393.2.D., if level of care or service needs have changed.

8.552.7.F. The Case Manager shall not authorize more than one consumer-directed program on the client's PAR.

8.552.7.G. The Case Manager shall participate in training and consultative opportunities with The Department's Consumer-Directed Training & Operations contractor.

8.552.7.H. Additional requirements for Case Managers:

1. Contact the client or Authorized Representative once a month during the first three months of receiving IHSS to assess their IHSS management, their satisfaction with Attendants, and the quality of services received.

2. Contact the client or Authorized Representative quarterly, after the first three months of receiving IHSS, to assess their implementation of Care Plans, IHSS management, quality of care, IHSS expenditures and general satisfaction.

3. Contact the client or Authorized Representative when a change in Authorized Representative occurs and continue contact once a month for three months after the change takes place.

4. Contact the IHSS Agency semi-annually to review the Care Plan, services provided by the agency, and supervision provided. The Case Manager must document and keep record of the following:

    a. IHSS Care Plans;

    b. In-home supervision needs as recommended by the Physician;

    c. Independent Living Core Services offered and provided by the IHSS Agency; and

    d. Additional supports provided to the client by the IHSS Agency.

8.552.7.I. Start of Services

1. Services may begin only after the requirements defined at Sections 8.552.2, 8.552.6.E., 8.552.6.I., and 8.552.7.C. have been met.

2. Department review for cost-containment as defined at Sections 8.486.80 and 8.506.12 must be completed prior to issuance of the PAR to the IHSS Agency.

3. The Case Manager shall establish a service period and submit a PAR, providing a copy to the IHSS Agency prior to the start of services.

8.552.8 REIMBURSEMENT AND SERVICE LIMITATIONS

8.552.8.A. IHSS services must be documented on an approved IHSS Care Plan and prior authorized before any services are rendered. The IHSS Care Plan and PAR must be submitted and approved by the Case Manager and received by the IHSS Agency prior to services being rendered. Services rendered in advance of approval and receipt of these documents are not reimbursable.

8.552.8.B. IHSS Personal Care services must comply with the rules for reimbursement set forth at Section 8.489.50. IHSS Homemaker services must comply with the rules for reimbursement set forth at Section 8.490.5.

8.552.8.C. Family Members are authorized to provide only Personal Care services or Health Maintenance Activities for eligible adults and Health Maintenance Activities for eligible children.

8.552.8.D. Services rendered by an Attendant who shares living space with the client or Family Members are reimbursable only when there is a determination by the Case Manager, made prior to the services being rendered, that the services meet the definition of Extraordinary Care.

8.552.8.E. Family Members shall not be reimbursed for more than forty (40) hours of Personal Care services in a seven (7) day period.

8.552.8.F. Health Maintenance Activities may include related Personal Care and/or Homemaker services if such tasks are completed in conjunction with the Health Maintenance Activity and are secondary or contiguous to the Health Maintenance Activity.

a. Secondary means in support of the main task(s). Secondary tasks must be routine and regularly performed in conjunction with a Health Maintenance Activity. There must be documented evidence that the secondary task is necessary for the health and safety of the client. Secondary tasks do not add units to the care plan.

b. Contiguous means before, during or after the main task(s). Contiguous tasks must be completed before, during, or after the Health Maintenance Activity. There must be documented evidence that the contiguous task is necessary for the health and safety of the client. Contiguous tasks do not add units to the care plan.

c. The IHSS Agency shall not submit claims for Health Maintenance Activities when only Personal Care and/or Homemaking services are completed.

8.552.8.G. Restrictions on allowable Personal Care units shall not apply to parents who provide Attendant services to their eligible adult children under In-Home Support Services as set forth at Section 8.485.204.D.

8.552.8.H. The IHSS Agency shall not submit claims for services missing documentation of the services rendered, for services which are not on the Care Plan, or for services which are not on an approved PAR. The IHSS Agency shall not submit claims for more time or units than were required to render the service regardless of whether more time or units were prior authorized. Reimbursement for claims for such services is not allowable.

8.522.8.I. The IHSS Agency shall request a reallocation of previously authorized service units for 24-hour back-up care prior to submission of a claim.

8.552.8.J. Services by an Authorized Representative to represent the client are not reimbursable. IHSS services performed by an Authorized Representative for the client that they represent are not reimbursable.

8.552.8.K. An IHSS Agency shall not be reimbursed for more than twenty-four hours of IHSS service in one day by an Attendant for one or more clients collectively.

8.552.8.L. A client cannot receive IHSS and Consumer Directed Attendant Support Services (CDASS) at the same time.

8.552.8.M. Independent Living Core Services, attendant training, and oversight or supervision provided by the IHSS Agency's Licensed Health Care Professional are not separately reimbursable. No additional compensation is allowable for IHSS Agencies for providing these services.

8.552.8.N. Travel time shall not be reimbursed.

8.552.8.O. Companionship is not a benefit of IHSS and shall not be reimbursed.

8.552.9 DISCONTINUATION AND TERMINATION OF IN-HOME SUPPORT SERVICES

8.552.9.A. A client may elect to discontinue IHSS or use an alternate service-delivery option at any time.

8.552.9.B. A client may be discontinued from IHSS when equivalent care in the community has been secured.

8.552.9.C. The Case Manager may terminate a client's participation in IHSS for the following reasons:

1. The client or their Authorized Representative fails to comply with IHSS program requirements as defined in Section 8.552.4, or

2. A client no longer meets program criteria, or

3. The client provides false information, false records, or is convicted of fraud, or

4. The client or their Authorized Representative exhibits Inappropriate Behavior and The Department has determined that the IHSS Agency has made adequate attempts at dispute resolution and dispute resolution has failed.

    a. The IHSS Agency and Case Manager are required to assist the client or their Authorized Representative to resolve the Inappropriate Behavior, which may include the addition of or a change of Authorized Representative. All attempts to resolve the Inappropriate Behavior must be documented prior to notice of termination

8.552.9.D. When an IHSS Agency discontinues services, the agency shall give the client and the client's Authorized Representative written notice of at least thirty days. Notice shall be provided in person, by certified mail or another verifiable-receipt service. Notice shall be considered given when it is documented that the client or Authorized Representative has received the notice. The notice shall provide the reason for discontinuation. A copy of the 30-day notice shall be given to the Case Management Agency.

1. Exceptions will be made to the requirement for advanced notice when the IHSS Agency has documented that there is an immediate threat to the client, IHSS Agency, or Attendants.

2. Upon IHSS Agency discretion, the agency may allow the client or their Authorized Representative to use the 30-day notice period to address conflicts that have resulted in discontinuation.

8.552.9.E. If continued services are needed with another agency, the current IHSS Agency shall collaborate with the Case Manager and client or their Authorized Representative to facilitate a smooth transition between agencies. The IHSS Agency shall document due diligence in ensuring continuity of care upon discharge as necessary to protect the client's safety and welfare.

8.552.9.F. In the event of discontinuation or termination from IHSS, the Case Manager shall:

1. Complete the Notice Services Status (LTC-803) and provide the client or the Authorized Representative with the reasons for termination, information about the client's rights to fair hearing, and appeal procedures. Once notice has been given, the client or Authorized Representative may contact the Case Manager for assistance in obtaining other home care services or additional benefits if needed.